Tanzania Human Resources Capacity Project (THRP)

Review of Recruitment Challenges of Health Workers in Tanzania and Ways of Closing the Gaps:

Case of Local Government Recruitment Practices and Underlying Principles

February, 2010

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List of Acronyms and Abbreviations

AMO	Assistant Medical Officer
BMAF	Benjamin Mkapa HIV/AIDS Foundation
CG	Central Government
CHMT	Council Health Management Team
DED	District Executive Directors
DPA	Director of Personnel & Administration
DPs	Development Partners
DHS	District Health Secretary
DHRO	District Human Resources Officer
EHP	Emergency Hiring Project
GoT	Government of Tanzania
HSRP	Health Sector Reform Program
HSSP	Health Sector Strategic Plan
IHI	Intra Health International
LG	Local Government
LGAs	Local Government Authorities
LGRP	Local Government Reform Program
MDAs	Ministries, Departments, and Agencies
MFP	Mkapa Fellow Program
MO	Medical Officer
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Tanzania
MTEF	Medium Term Expenditure Framework
MoFEA	Ministry of Finance & Economic
MoHSW	Ministry of Health and Social Welfare
MTPs	Medium Term Plans
MTSPBF	Medium Term Strategic Planning & Budget Framework
MNF	Mwalimu Nyerere Fund
NPBGs	National Planning and Budgeting Guidelines
O&OD	Opportunity and Obstacle to Development
PE	Personnel Emoluments
PER	Public expenditure Review
PO-PSM	Presidents Office-Public Service Management
PMPRALG	Prime Minister's Office Regional Adm. & Local Govt.
PSR	Public Service Reform
PSRP	Public Service Reform Programme
PSPIP	Public Service Pay and Incentive Policy
USAID	United States Agency for International Development

Disclaimer

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1.0 EXECUTIVE SUMMARY

1.1 Overview

This review provides a situational analysis of recruitment and retention of health workers in Tanzania, with a specific focus on districts. The report outlines challenges related to planning, recruitment and retention of health workers. The report also makes recommendations on closing the gaps based on perceptions from parties involved during the review. In the context of this report, recruitment challenges are taken as major obstacles to acquisition, placement, motivating and retaining the health professionals in the districts at various stages of the recruitment and retention processes.

This review is a follow up of a pilot assessment (2009) of recruitment bottlenecks which was conducted in four pilot districts of Mwanga, Same and Rombo in Kilimanjaro region. The pilot assessment; despite being able to uncover numerous recruitment and retention challenges of health workers in districts, had a number of limitations. These include minimal stakeholder involvement during the study, and minimal focus on institutional arrangement governing recruitment and retention of health workers at the central and local government levels. Furthermore, the pilot study was conducted during a decentralised recruitment arrangement of health workers as opposed to the current centralised arrangement.

1.2 Problem Statement

Despite various measures taken by the Government of Tanzania (GoT), recent studies have reported severe shortages of health workers in most health care facilities in districts. The shortage of quality and quantity affect the quality of health care services. Crown (2005), asserts that 'A major factor constraining the capability of Local Government Authorities

(LGAs) to **meet the service delivery, quality and accessibility** aspirations of their constituencies is their limited capacity to attract, retain and adequately motivate the requisite qualified skilled personnel.[1]

The shortage of health workers in the districts has received due attention in various public service reform programmes and related initiatives; including different phases of Public Service Reform Program (PSRP), Local Government Reform Program (LGRP) and Health Sector Reform Program (HSRP).

Further, there have been a number of coordinated programs to support recruitment and retention of health workers in the country; which were jointly managed between the Government of Tanzania (GoT) and Development Partners (DPs). These include the Mkapa Fellow Program (MFP), Emergency Hiring Program (EHP) and Mwalimu Nyerere Fund (MNF), among others. The schemes provided various incentives to attract health workers in the districts, especially underserved areas.

Despite the existence of various interventions, the plight of attracting and retaining competent health workers in district health facilities has continued to worsen, raising questions as to whether the completed and ongoing efforts have adequately addressed the real problems. The purpose of this report is to provide a critical assessment of current recruitment processes and practices, underlying assumptions and implications. The findings should help policy makers and other concerned actors to make evidence-based decisions in addressing recruitment and retention challenges in the districts.

In the context of the above, and as a follow-up initiative of numerous gaps identified during the pilot study, the Benjamin William Mkapa HIV/AIDS Foundation (BMAF) and Intra-Health International (IHI), subsequently, with the support of USAID commissioned this review.

1.3 Study Design and Approach

The methodology used in this review combined literature review, face-to-face structured interviews and focus group discussions with key informants. The review began with an institutional mapping. This entailed identification of key institutions involved in recruitment and retention of

[1] Consultancy on the staffing problems of peripheral or otherwise disadvantaged Local Government Authorities, a joint report between Crown Management Consultants and PEM Consult East Africa Limited discusses page.1. The report was commissioned by PMORALG to provide input to LGRP.

health workers, as well as identification of key informants to be involved in the review.

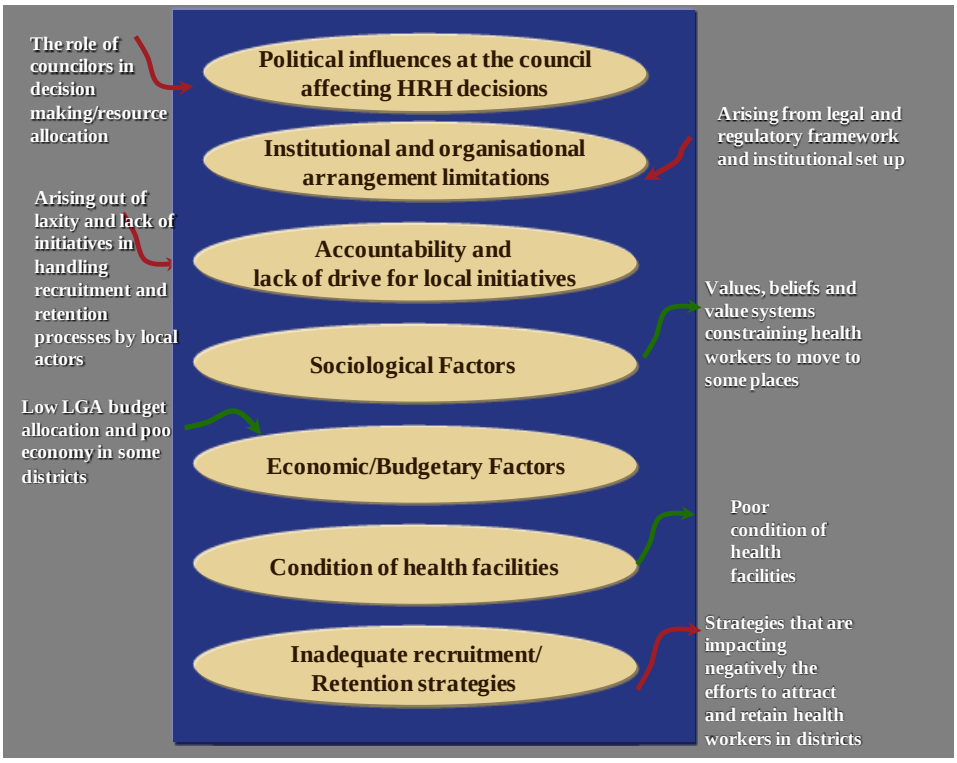
1.4 Key Findings

The review illustrates the numerous practical constraints in the recruitment and retention strategies and processes, as they related to the health sector in the districts and lower level health facilities.

Apart from macro economic, political and social factors in rural areas, such as poor state of infrastructure and unavailability of social services which hinder competent health workers to relocate to some districts, the review identified 'softer' factors such as institutional and organisational arrangement, accountability and initiative that have equally impeded the ability of the Local Government Authorities (LGAs) to attract, motivate and retain health workers in some areas. Some of these softer constraints could be eased with minimal costs through modifying current policies and processes, as well as streamlining interface between various government entities and fostering accountability and instituting control mechanisms in recruitment and retention practices.

Figure 1.1 illustrates some of the identified constraints under the categories of: economic factors/budgetary, political influences, conditions of health facilities, institutional arrangement, and accountability.

Figure 1.1 Summary of major recruitment and retention constraints



1.5 Summary of Recommendations

The following key recommendations are made with consideration that this will help decision makers at the Central and Local Government levels to make evidence-based decisions related to minimizing the gap between recruitment and retention in the districts.

This review recommends the re-definition and harmonization of the roles of various institutions that are mandated to handle recruitment and retention of health workers in and for the districts. These institutions include the Ministry of Health and Social Welfare (MoHSW), Prime Minister's Office Regional Administration and Local Government (PMORALG), President's Office Public Service Management (POPSM) as well as other organs such as the Employment Secretariat. Other institutions include the Councils Health Management Teams (CHMTs) and Employment Boards in the Districts.

Decongestion of the office of District Human Resource Officers (DHRO) could be eased by re-directing some human resources roles, especially those related to HRH, to Health Secretaries (HSs). It is envisioned that this would reduce delays in handling HR matters in the districts and subsequently improve staff satisfaction and retention.

In order to enhance the effectiveness of HRH planning, the review recommends mainstreaming HRH planning within the overall Opportunity and Obstacles to Development (O&OD) framework. Utilizing this framework could enable communities to take active roles in addressing recruitment and retention barriers at the community level. If the communities are actively involved, they may be able to help address local incentives such as housing problems as well as social constraints to recruitment at community level.

Modifying current HRH forecasting methodologies could help to better determine the actual HRH demand nationally, and in specific districts and communities. More precise forecasting methodologies will support the adoption of mechanisms for effective distribution and re-distribution of health workers throughout the country.

It is highly recommended that LGAs should consider introducing localized special incentives, over and above those described in public service policies and regulations in order to attract health workers in specific localities. Given the existing regional disparities, instituting local initiatives to address specific constraints at the LGAs level, as opposed to relying on central government directives would easily resolve the constraints. During the review, it was evident that LGAs which have introduced local incentives have resolved recruitment and retention bottlenecks to some extent (Bottleneck pilot study, 2009).[2]

Finally, building the capacity of local organs and actors such as CHMTs and DHROs to address previously identified constraints would preferable over centralizing most of the processes; which has proved to be time consuming and ineffective.

1.6 Remarks

The constraints to recruitment and retention of health workers in the districts require a nationwide and multi -sector approach that may require large resources. These constraints include: economic conditions, infrastructure, and LGA budget allocation. However, some softer constraints such as accountability, process improvement and instituting practical local initiatives may be eased by minimal efforts and resources.

[2] Recruitment Bottleneck study, a pilot assessment conducted by BMAF in 2009 in three districts provides useful information of various local initiatives and the impact in recruitment and retention.

2. INTRODUCTION AND BACKGROUND

2.1 Introduction

This review is commissioned in the context of the fact that service delivery in the health sector, especially in rural areas is severely constrained by the shortage of key personnel. The situation is aggravated by limited government capacity to attract and retain qualified staff, especially in Districts. Comparatively, many studies have attributed the shortage of staff to undesirable geographical locations, low pay and poor incentives. However, this study demonstrates that other factors such as inadequate recruitment strategies and poor institutional and organisational factors limit the ability of the districts to attract and retain health workers.

There have been successful local initiatives in some regions and districts that have addressed health worker shortage. For example, Rukwa region has introduced local incentives for different categories of professionals. These initiatives have eased health worker shortage. However, regions and districts that lack self initiatives have continued to suffer from severe shortage of qualified health personnel.

2.2 Objectives and Scope

The Benjamin William Mkapa HIV/AIDS Foundation (BMAF) and Intra-Health International, with the support of USAID, commissioned this review to follow up on the gaps identified in the 2009 pilot study. The Terms of Reference are attached as **Appendix 1** and summarised below:

a) Assess current recruitment and placement practices of health workers, as a basis for establishing policies, practices, and interventions that will enable the health sector to bridge the staffing gaps.

b) Review the current method(s) used by the public service in the health sector in Tanzania to plan, budget and recruit. This information will help inform policy makers on the ways in which to improve human resources for health management in line with best practice strategies.
c) Provide policy recommendations for inclusion into IntraHealth strategies and interventions on the means for closing the gaps inrecruitment, placement, promotion and retention gaps.These strategic policy recommendations should include the means by which existing institutional and organisational arrangement gaps would be addressed.

2.3 Descriptive Summary of Approach

The methodology for performing the assignment was significantly influenced by the observations and exigencies identified during the problem identification and study design. In these contexts, the methodology used in this study included a literature review, face-to-face interviews and focus group discussions with selected key informants.

The study commenced with a policy review of government documentation related to human resources planning, recruitment in the public sector in Tanzania, and in the health sector in particular. The documents reviewed included: the Public Services Act, government employment policies and guidelines as well as recent studies on the subjects (Appendix 2 provides the references). During the inception of the study, consultations were undertaken with senior members of the Benjamin Mkapa HIV/AIDS to clarify the objectives. An institutional mapping was undertaken in order to identify institutions and key informants which were to be involved.

Questionnaires and focus group tools were developed and administered to collect information on the processes of planning and budgeting for human resources, as well as policies and guidelines related to recruitment and posting of health workers. Focus group discussion involved the human resources officers who are responsible for recruitment and positing of health workers at the MoHSW.

2.4 Data collection and analytical tools

Secondary data collection

Documentary sources were the main sources of information reviewed to dig out relevant information for this review. These include policy documents, reports and other documentary sources that were made available to the researcher. The focus was to review policies and guidelines that impact of recruitment and retention of health workers in LGAs.

Primary data collection

The assumption of this review was that perceptions, feelings and impressions of the important key actors in the relevant ministries and LGAs were very important in gathering information related to recruitment and retention bottlenecks of health workers

The following data collection tools were used to collect primary date during the review:

a) **Questionnaire No. 1 – administered to the Assistant Director/Establishment Department of Establishment - President's Office Public Service Management,** was designed to collect data on the establishment of practices and processes related to planning, budgeting and management of human resources.

b) **Questionnaire No. 2 – was administered to the Assistant Director/Policy Department in the President's Office Public Service Management**, and was used as a tool to collect data about the current knowledge base on existing policies and guidelines related to the recruitment and retention of employees in the public service, with specific focus on the health sector.

c) **Questionnaire No. 3 – was administered to the Recruitment Officers – MoHSW** and was used to **collect information on current** knowledge related to the recruitment processes, challenges and health sector guidelines from the Directorate of Personnel and Administration.

d) **Questionnaire No. 4 – was administered to the Officers of the Human Resources Department, MoHSW**, and was designed to gather facts on the production/supply of health workers.

e) **Questionnaire No. 5 was administered to the Human Resources Officer, PMO-RALG,** and was designed to collect information about recruitment challenges from a LGA perspective.

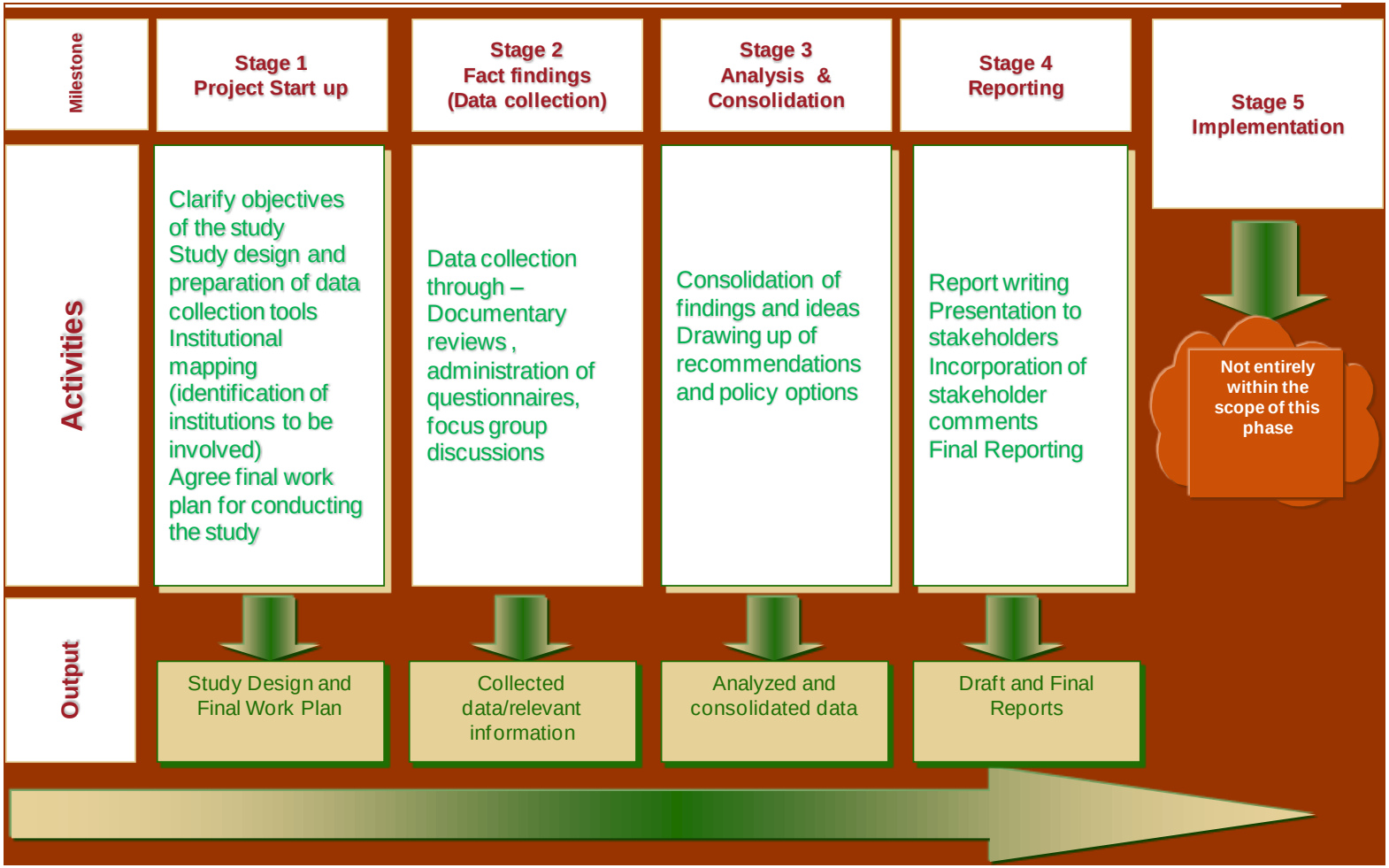
2. 5 Scope of the analysis

Analysis of this review was limited to the objectives and problem statement identified in this report. Although the information obtained in some areas may not have been sufficient to make country-wide conclusions, the

selected data and information obtained from respondents and other sources still constituted a test case.

Therefore, in as much as the review has not been able to cover the entire health sector and other stakeholders involved in recruitment and retention of health workers at LGAs, or review all the relevant operations and processes, the outcome has provided a fair idea of the issues in general.

Figure: 2.1 Summary of approach and methodology



2.5 Limitations of the Study

This review does not pretend to be free from limitations. Although the findings and conclusions are not affected, it is important to highlight some of the limitations. The availability of reliable data and statistics related to the number of health workers recruited for, and reported to, a specific post was not available. Furthermore, there is no data regarding 'why' a health worker did not report to their duty station. There is also no reliable statistics on the rate of staff turnover and where staff relocate upon leaving a post. In light of this limitation, we drew some conclusions on data collected from pilot studies, and information provided by key informants from in-depth interviews and focus group discussions.

A second limitation of the study was the inability to review the new Public Service Pay and Incentives Policy (PSPIP) which was in a draft form and unavailable to the public. The inability to review this policy is an important limitation given that pay is a major factor in recruitment and retention at the district level, especially underserved areas in the country.

Thirdly, it is also possible that some respondents did not provide their honest opinions on some matters, especially failures that could be perceived as lack of capacity on their part.

2.6 Outline of the reminder of the report

The remainder of this report is presented under the following headings:

Chapter Three: Examines the status of human resources for health in the country, with the focus on demand and supply as well as the surrounding dynamics and the way they affect the districts.

Chapter Four: Covers an institutional analysis of recruitment of health workers, where the roles of various institutions involved in recruitment and retention of health (for districts) as well as various employment policies and guidelines are examined.

Chapter Five: Examines the current strategies for planning and budgeting, recruitment and retention of health workers, their underlying assumptions and their effectiveness.

Chapter Six: Covers macro social, economic and political factors affecting recruitment and retention of health workers in districts.

Chapter Seven: Presents selected lessons from successful recruitment stories in the districts, a summary of findings, conclusion and next recommended next steps.

3. A SYNOPSIS OF THE STATUS OF HUMAN RESOURCES FOR HEALTH IN TANZANIA AND THE DISTRICTS

3.1 Introduction

Previous studies and discussions we held during the review attest that Tanzania in general and district level in particular are facing a severe shortage of qualified health workers. The rural communities are worse hit by this situation. Poor infrastructure, coupled with poor remuneration of health professionals and lack of differential incentives are some of the most sited constraints that make it extremely difficult to attract and retain health personnel to work in rural areas. We provide facts and figures in the following sections as identified during the review.

3.2 Adequacy of staff numbers and quality of health workers in Tanzania

3.2.1 Overview

Tanzania has an estimated 29,000 health workers, many of whom are unskilled. The ratio of doctors to population is 1:20,000 people. Approximately 51% of all practicing medical doctors are in Dar es Salaam. The number of staff working at the districts and regional levels is only 35% which is below the staffing level required by MoHSW standards (Ministry of Health Annual Sector review, 2006).

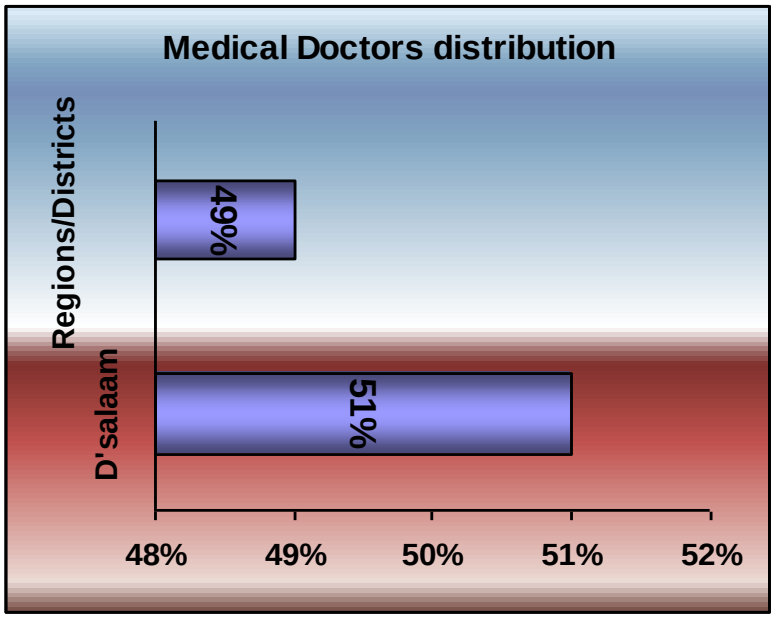
An interview with a senior officer at the Directorate of Establishment (POPSM) described the shortage of health in the country, especially in rural areas as 'pathetic'. The quality improvement department of the MoHSW also stated that there are some stations in rural areas that are being managed by unqualified personnel, including Medical Attendants (MAs) due to the current shortage.

It is imperative to consider the adequacy of health workers based on both numbers and quality. There are complaints that many districts are staffed with unskilled or semi-skilled health workers. This situation may definitely affect service quality. The Health Workforce Initiative (HWI) Fact Findings (2009) indicated that some councils reported they were sent with more Medical Attendants (MAs) than they had requested. Cited districts include Muleba, Liwale, Nachingwea and Urambo.

3.2.2 Distribution of Health Workers in the Country

Recent studies indicate that available qualified health workers are not equitably distributed across the country. According to recent reports, 51% of qualified doctors are based in Dar es Salaam and the remaining 49% are un-evenly distributed in other regions (POPSM, 2009). This scenario is illustrated in figure 3.1 below.

Figure 3.1 Distribution of Medical Doctors in Tanzania



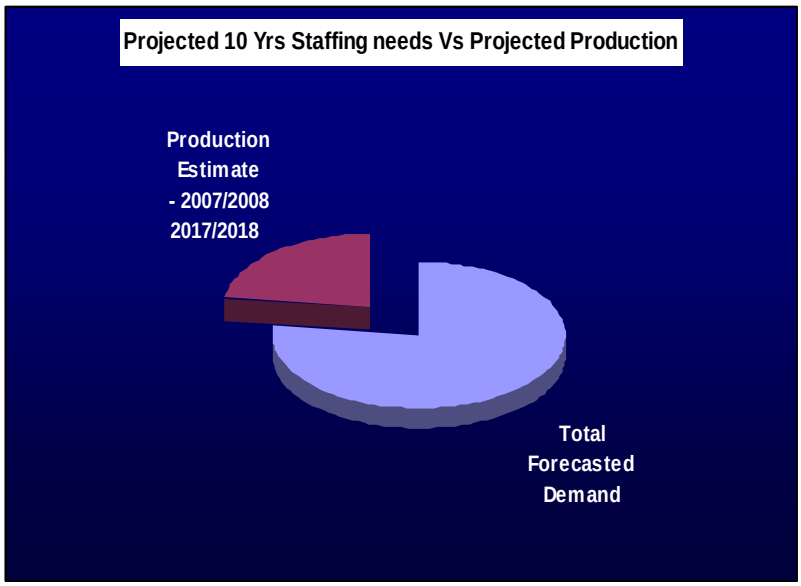
Source: POPSM Study, 2009

3.2.3 Human Resources Production and Supply

The availability of health workers in the market is a key determinant factor in addressing the problem of health workers shortage. Our documentary review indicates variances between current and planned production/supply capacity and the current and future demand of health workers in the country.

The shortage of health workers in districts is attributed to limited supply. A recent study by the HRH working group (2009) provides useful statistics indicating the variances between projected production of health professionals (nationally) and forecasted demand in the next eight to ten years. From presented statistics in the report, as illustrated in Figure 3.2. below, if the current production is not increased exponentially, eight years from now the country will still be facing a shortage of around 75%.

Figure 3.2 HRH Supply Vs Demand (by 2018)



Source: Extracted from HRH Working Group Analysis, 2009

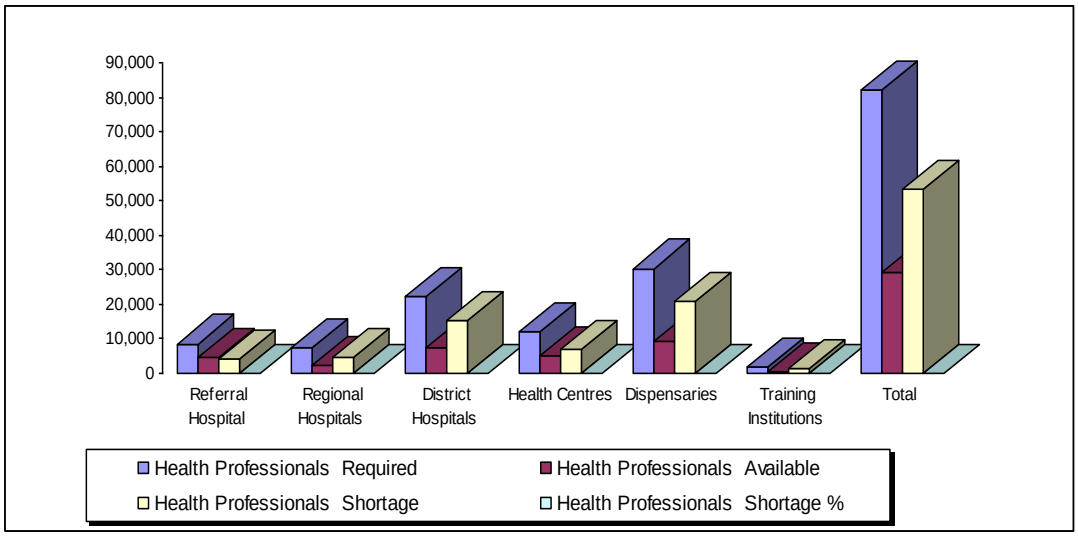
There are a number of challenges the government is currently facing in ramping up production of health workers. One is the situation of government health training institutions. Challenges facing these institutions include shortage of full time tutors, limited infrastructure (classrooms, laboratory and dormitories). Other factors are limited funding and limited number of enrolled students due to cost sharing arrangement (I-TECH, 2010).[3]

3.2.4 Distribution of health workers by facility category

Shortage of health workers in districts, especially underserved areas is also attributed to distribution. Statistics on the distribution of health workers by facility category indicate the existence of distribution gaps. Dispensaries (village level), Health Care Centres (ward level) and Districts Hospitals are the most affected facility categories. Figure 3.3 illustrates the distribution gaps (POPSM).

[3] A situational analysis of Government Clinical Officer/Clinical Assistant Training Institutions conducted by I-TECH IN 2010 provides a detailed analysis of the status of government training institutions and the required improvements that will increase enrollment level, especially of mid level health workers.

Figure 3.3 Distribution of health workers by facility category



SOURCE: POPSM, Unpublished presentation, 2010

3.2.5 Distribution of health workers by cadre (Approved Establishment Vs Filled Positions)

Dr. Sichalwe (2010), in his presentation indicates the average deficit of 42% (staffing norms/approved establishment vs. filled positions).[4] This implies that the current supply is not sufficient to meet the demand, even for budgeted positions. Table 3.1 below indicates the shortfall of HRH (establishment vs. availability) by cadre.

Table 3.1 Distribution of health workers by cadre

Cadre	Establishment	Available	Shortfall	%Shortage
Specialist Doctors	229	96	133	58.10%
Nurse/-NW/PHN II	20,373	9,241	11,132	54.60%
Radiographer	197	97	100	50.80%
Clinical Officers	11,316	5,655	5,661	50.00%
Pharmacist/Technician	621	311	310	49.90%
AMO/ADO	2,407	1,295	1,112	46.20%
Health Officers	1,823	990	833	45.70%

[4] These facts were extracted from works of Dr. Sichalwe, (unpublished presentation) one of the leaders in the sector in Tanzania which was made during one of the meetings organized by the president's office public service management. The presentation indicates the source of data being the government pay roll.

Lab. Techn. Lab	821	480	341	41.50%
Ass, Clinical officers/ MCHA	760	451	309	40.70%
Medical Doctors	748	469	279	37.30%
Nursing Officers/ PHNA	6,559	4,381	2,178	33.20%
Health Secretaries	269	196	73	27.10%
Others\ Medical Attendants	24,154	18,891	5,263	21.80%
Total	**70,277**	**42,553**	**27,724**	**39.40%**

Source: Extracted from Dr. Sichalwe,s presentation, 2010 (Unpublished presentation)

3.3 Attrition of health workers in districts

There are a number of reasons for staff attrition in the health sector in Tanzania. Deaths, retirement, termination due to misconduct and 'brain drain' (local and international) are some of the common factors recorded in various studies. There must be a balance between HRH supply and attrition rate in order to maintain service delivery in health facilities.

A recent HWI fact finding mission held in September 2009 provides evidence of high labour turnover of health workers in districts. Examples of the mission's findings are highlighted below:

- Mpanda district was reported to have 46 clinical officers in February 2008, but in May 2009 they reported having 22.
- Over the same period, only one new clinical officer reported to this station out of six requested.
- Sikonge district lost 14 staff in 2007/2008 but gained only three over the same period.
- Liwale, Ruangwa, Nachingwea, Muleba and Urambo reported that they received more Medical Attendants than they had requested. This signifies limitations in supply of qualified health personnel vs. the qualified ones.

3.4 Forecasting of human resources for health in Tanzania

An effective human resources recruitment plan is dependent on the accuracy of forecasting. Health workers demand according to Health Sector Strategic Plan (HSSP3) is determined on the basis of number of health professionals per population (i.e. One Medical Officer and Assistant Medical Officer per 10,000 people by region). A different approach to forecasting is indicated in Primary Health Services Development Program (PSDP), where forecasting is based on cadres by facility type (estimated number of health workers by category per level of health facility times number of facilities in that category).

During the review it was found that HRH projections based on 'health worker to population' do not take into account the health workers who are deployed in non public health facilities, although they are serving the same population.

During this review, it was not clear whether HRH demand per facility has been fully adopted across the country. Further rendering to the question as to whether the current and future estimated HRH demand is realistic.

3.5 Absenteeism due to attendance of long term training

The authors of the review found that the shortage of worker is exacerbated by health workers who are engaged in long-term training for more than five years. Interviewees indicated that some people opt to go for long term training as a way of avoiding to work in the districts and underserved areas. This occurs in part due to loosely tailored training policies and regulations. Sources indicated that some people would attend up to three courses consecutively in order to avoid reporting to their duty stations.

3.6 Remarks

As we have seen from various studies and reviews:

- There is a mismatch between the current, estimated future supply of health workers and the projected current and future needs,
- Despite the current strategies in place to increase production capacity of health workers, studies have attested that, ten years to come the shortage of health workers is likely to widen up to 85%,
- Health workers are not evenly distributed in the country and this misdistribution has the greatest impact on districts and lower level health facilities.

- Due to existing shortage, districts have been receiving semi-skilled laborers in lieu of the skilled ones. This is affecting the quality of health services in districts,
- Attrition rate in very high in some districts as indicated in section 3.3 of this report in this report, necessitating the need for a thorough review of current recruitment and retention strategies in place,
- There is lack of consistency in the utilization of HRH forecasting methodologies. The lack of consistency renders it difficult to conclude whether the reported shortage is accurate.

4. INSTITUTIONAL ANALYSIS OF HUMAN RESOURCES PLANNING & BUDGETING, RECRUITMENT AND RETENTION OF HEALTH WORKERS IN THE DISTRICTS

4.1 Introduction

This section of the report provides an institutional analysis of different actors in human resources planning, budgeting, recruitment, placement and retention of public service employees, with special focus on LGA employees of the health sector. The relationship between institutional arrangements and the ways in which it affects the recruitment and retention processes is an important issue in order to understand the existing challenges.

In order to avoid confusion, this report uses the term **"Institutional",** to refer to various organisations, agencies, ministries etc. (collectively "institutions") that are involved in the planning, budgeting recruitment, and retention of health workers in the districts (e.g. the DED, POPSM, PMORGLA, MOHSW).. It includes the legislation and other legal instruments and statutes that empower those institutions and the necessary interactions, one with another, essential to control the processes effectively. Institutional analysis examines the interactions between various bodies involved in recruitment and retention processes.

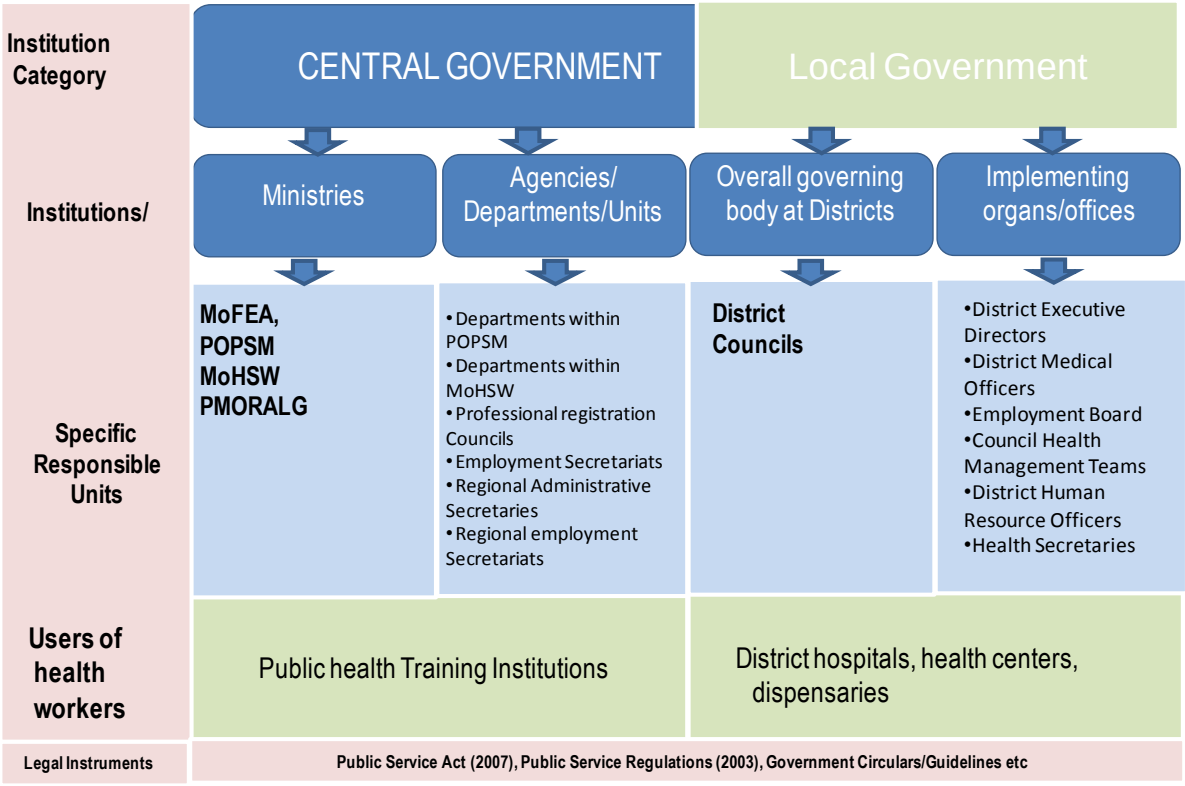
4.2 The Institutional Arrangement

The institutional framework in the planning and budgeting for health workers, as well as the recruitment and retention were found to be composed of institutions at central ministries and those at the LGAs. The central government has the biggest role in the process. The roles, which will be further described in the following sections include: setting and enforcing legislation and regulations; recruitment of health workers (under a centralised recruitment arrangement as well as regulatory roles. The key ministries that are involved in this process include: the POPSM, PMORALG, MoHSW and the MoFEA.

The District Executive Directors are employers of all health workers in the districts and they are part of the planning, recruitment and retention processes. It is however important to note that there are various institutions outside the formal government system which have been supplementing and complementing government efforts in the efforts to attract, recruit and retain qualified heath workers in the districts. These include donor supported

institutions such as the Benjamin William Mkapa HIV/AIDS Foundation (BMAF) etc. Figure 4.1 below indicates the formal institutional arrangement. The next sections outline the roles, and constraints, of various institutions..

Figure: 4.1 Institutional arrangement for recruitment/retention of HRH



4.3 Institutional Analysis

This section of the report highlights the major roles of various organs/ units involved in recruitment and retention of health workers in the country.

The President's Office Public Service Management (POPSM)

POPSM is responsible for recruitment and retention in the public service, including health workers in accordance with the Public Service Act (2007), Public Service Management Employment Policy (2008), Public Service Regulations (2003), Public Service Scheme (2003) and others. The following list illustrates some of the activities that directly impact on recruitment and retention:

- Enactment of employment policies and guidelines in the public service,

- Setting PE budget guidelines,
- Scrutiny and approval of PE budget (Establishment),
- Issuance of approvals for hiring of staff upon receiving requests from respective employers (DES's),
- Registration of new hires into the public service payroll upon receipt of advice and necessary documents from employers,
- Monitoring the establishments, the wage bill and the payroll.

Public Service Employment Secretariats

Section 29 of the Public Service Act (2007), introduces the Public Service Secretariat at POPSM which has representatives in every region. Discussions at POPSM indicated that formulation of this secretariat was underway.

Specific functions of the secretariat include the following:

- Identify graduates in various disciplines such as medical professionals, Engineers, lawyers etc and maintain a database of the same,
- Maintain a register of professionals within the public services
- Prepare and make advertisements for vacant positions when necessary
- Identify interview and selection panels
- Advise employers of the public service on recruitment and employment issues.

Ministry of Health and Social Welfare (MoHSW)

The MoHSW plays a critical role in recruitment, placement and retention of health workers. The MoHSW is charged with the management of health services but it is also responsible for health policies and strategies as well as establishing and regulating professional ethics and guidelines which directly affect recruitment and retention.

Under the centralised arrangement the MoHSW is responsible for advertising vacant positions throughout the country, and posting of applicants to respective employers (DEDs) for finalisation of recruitment processes, including signing of employment contracts. The rationale for this arrangement is a perceived limited capacity of councils to attract qualified staff. Despite the centralisation arrangement, the shortage of qualified health workers still persists.

Prime Minister's Office Regional Administration and Local Government (PMORALG)

Historically, no substantial recruitment and retention functions were placed under the PMORALG. i.e. PE budget planning, defending of establishments, writing of employment permits and the actual hiring activities are under the DEDs.

Ministry of Finance and Economic Affairs (MoFEA)

The Ministry of Finance and Economic Planning is involved in two critical stages of planning and the recruitment of health workers. The first stage of involvement is during the PE planning and budgeting process when the ministry sets PE ceilings for various votes with the government expenditure framework.

Secondly, the ministry, through treasury is involved in activation of new employed into the payroll through the treasury. When a new employee completes employment forms, payroll advice forms are then submitted by the DED to POPSM and then to Treasury for payroll registration and activation.

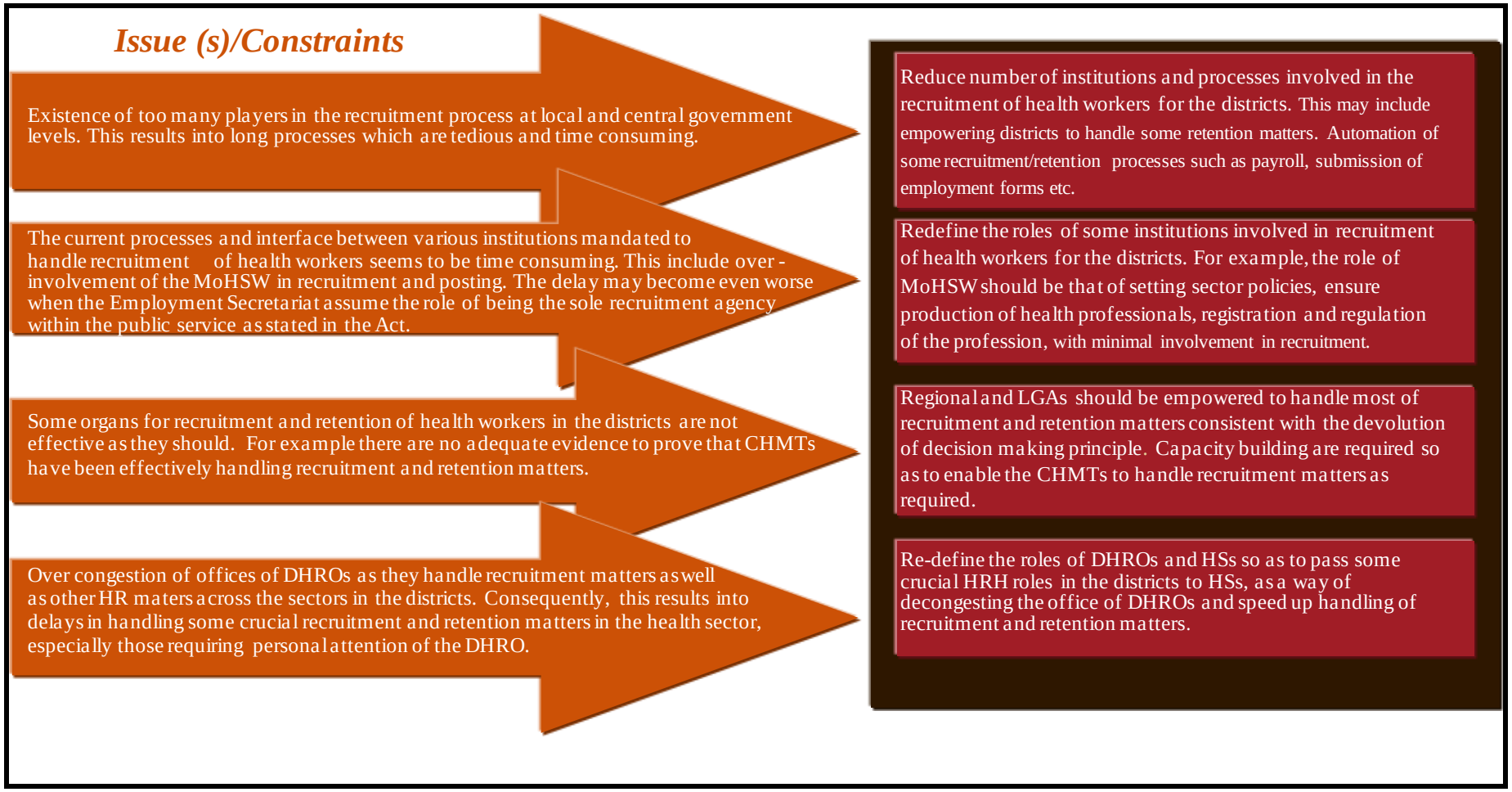
Local Government Authorities (LGAs)

The District Councils, which are headed by the District Executive Directors, are the official employers of health workers in the districts. The District Councils, under the leadership of DEDs are responsible for the planning (PE budgeting), recruitment and retention processes. The key actors under the Councils include: the Council Health Management Teams (CHMTs), the District Medical Officer (DMO), Health Secretaries (HSs) and District Human Resources Officers (DHRO).

Institutional Arrangement Constraint

In figure 4.2 below, we provide a summary of identified institutional arrangement constraints, as well as recommended remedial actions that will minimize or resolve these constraints.

Figure: 4.2 Summary of observed institutional arrangement constraints



4.4 Legal and regulatory framework

The legal and regulatory framework for recruitment and retention of health workers in the districts include Acts of Parliament, policies, rules, regulations and various government guidelines. In this study, we examined the Public Service Act, 2007 and its subsequent amendments, the Public Service Scheme, 2003 and Public Service Regulations, 2003. Other documents reviewed include circulars and guidelines issued by POPSM. The Health Sector Strategic Plan (HSSP) and the Primary Health Services Development Programme (MMAM) were reviewed in order to examine how these strategies and plans affect the recruitment and retention of health workers in the districts.

The Public Service Act, 2007

The Public Service Ac, 2007 establishes an Employment Secretariat at POPSM and branches in every region. Although the secretariat is not fully effective, it is given the mandate under the law to handle all recruitment processes in the public service (including the health workers). The mandate includes to:

- Identify graduates in various disciplines such as medical professionals, Engineers, Lawyers etc and maintain a database of the same,
- Maintain a register of professionals within the public services for easy of locating them whenever vacancies emerges,
- Prepare and make advertisement of vacant position where necessary
- Identify interview and selection panels
- Advice employers of the public service on various recruitment and employment matters.

It is obvious that once the secretariat is established it will operate on a centralised model where multi-sector recruitment needs will be addressed by a single agency. The question is whether this body (when it is fully established) will solve the current recruitment challenges or will accelerate the problems, especially in LGAs.

The Public Service Regulations, 2003

Section 149(3) of the Public Service Regulations, 2003 provides for certification requirement before appointment into the public service all professions that are regulated registration councils. These include medical professions.

During the review, it was discovered that there are health workers who are recruited and posted without receiving required professional certifications.

(Actual statistics was not made available). Furthermore, a periodic renewal of certification is not preceded by any performance review of a practicing medical professional.

Currently practicing applicants are only required to pay their annual subscription fees. The exercise is often seen as revenue collection strategy, rather than a professional regulation. Professional certification is seen as a substitute for interviews. Therefore, interviews for applying health workers are waived. Apart from the good intention of the law, the above practices may affect the quality of health workers who are being posted into the districts, and consequently create a negative effect in health service delivery.

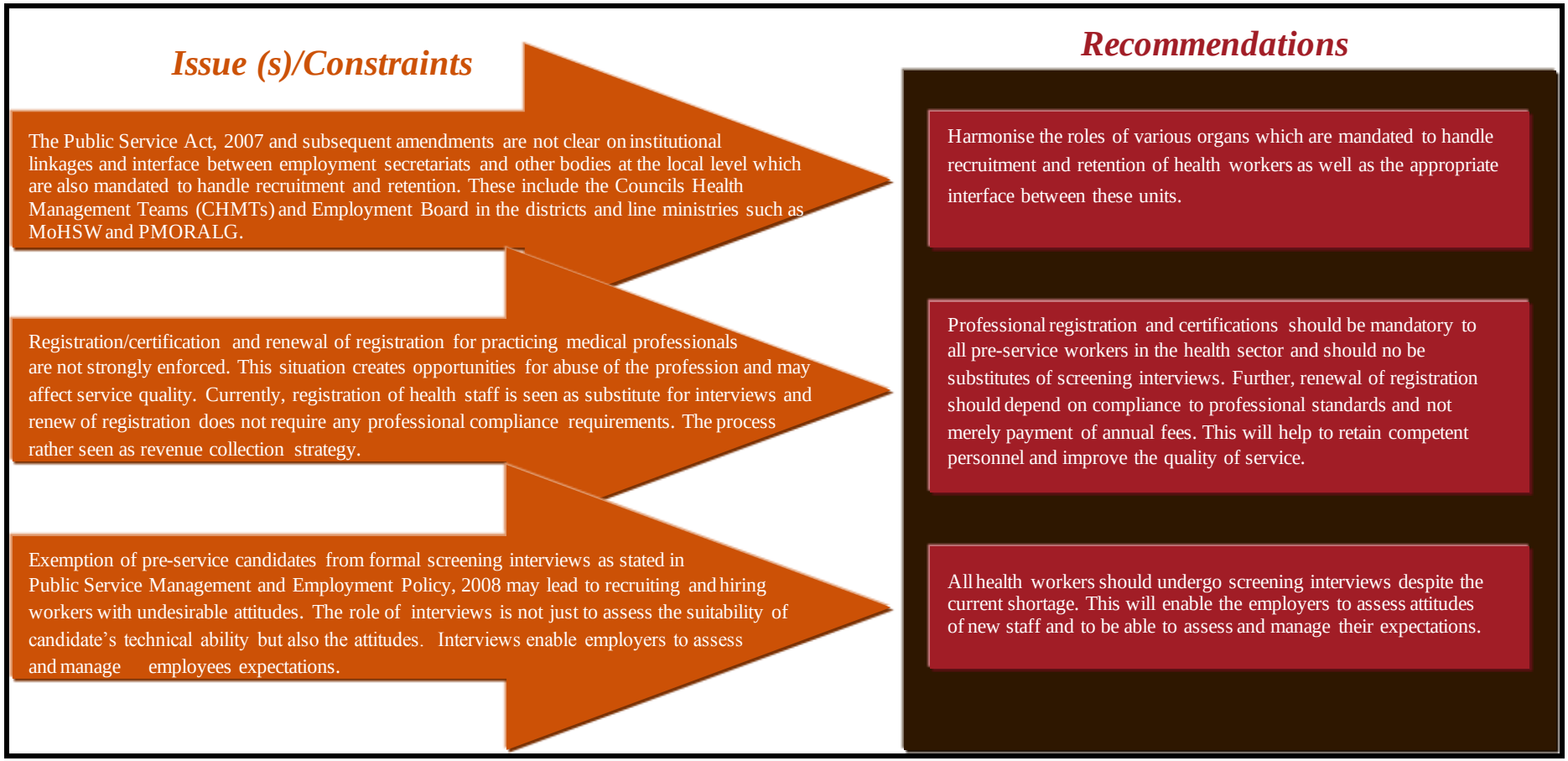
Public Service Management and Employment Policy, 2008

Section two of the Public Service Management and Employment Policy (2008) indicates that due to the shortage of staff, in certain cadres, there shall be no competitive interviews for such positions, especially those which are regulated by certain registration/regulatory bodies. The underlying assumption is that for such professions, which include various categories of health workers, the registration bodies will be effective enough to register only those candidates who meet technical and professional standards. If proper controls are not instituted, this regulation may result in supply of low quality personnel in the market. Due to the current shortage of health workers, districts are likely to suffer most.

Summary of legal and regulatory constraints and recommendations

A summary of legal and regulatory framework constraints inhibiting the ability of LGAs to recruit and retain competent health workers are indicated in figure 4.3 below. These include limitation of existing laws and certain regulations which hinders the ability of LGAs to have competent health workers.

Figure 4.3 Summary of issues and recommendations related to legal and regulatory aspects



5. REVIEW OF THE CURRENT STRATEGIES AND PROCESSES FOR PLANNING, RECRUITMENT AND RETENTION OF HEALTH WORKERS – A DISTRICT LEVEL PERSPECTIVE

5.1 Overview

This section of the report lays out various strategies and processes that are in place for human resources planning; recruitment and retention of health workers, and the way these processes affect the ability of the districts to attract and retain health workers. Recommendations have been included in the end to inform alternative policy options.

5.1.1 The Opportunity and Obstacle to Development Planning

Tanzania has been implementing local government reform, along with other reforms since 1990s. The reform process aims to ensure that citizens at the grassroots level are involved in the planning and implementation of development programmes in their local areas. Propelled by the decentralisation of responsibility and financial resources for delivering public services from central government to LGAs, the Opportunity and Obstacle to Development (O&OD) approach was initiated in 2002. This approach was utilized as a way to promote transparency and accountability in community development, through the introduction of participatory process in order to identify and prioritise community needs. Since 2009, the government has rolled out the O&OD planning framework in 105 of the 132 LGAs (LGRP, 2009).

O&OD approach is envisaged to be a bottom–up participatory planning method for local development. The O&OD promotes interactions and consultations between local communities and council management teams in social –economic planning and implementation.

The Medium Term Expenditure Framework (MTEF) and the Rolling Plan and Forward Budget (RPFB) including the PE budgeting seems to follow the O&OD framework and is expected to enable local priorities to be taken on board.

Observations

We observed the following issues with regards to the community planning model as it relates with the recruitment and retention of workers:

- Human resources planning in the districts is not clearly articulated as being part of O&OD framework,
- The overall planning approach in districts has continued to be interfered by the central government through pre-determined planning guidelines. In addition, the District Councils appear to be undermining the community plans due to political reasons (Brian et al, 2005).
- Brian et.al asserts that most of the Councils have been ignoring the priorities established by the communities due to political pressures at the full councils:

Table 5.1 below, indicates the Opportunity and Obstacles to Development Planning framework as it applies in Local Authorities.

Table: 5.1 O&OD Planning – A community perspective

Day	Rural	Urban
One	Social preparation and secondary data collection	
Two	Social preparation and secondary data collection	
Three	Extraordinary village assembly to launch O&OD; formation of Focus group selection of map drawers and community resource persons and primary data collection	Zonal/Mtaa meeting to launch O&OD; formation of focus group Selection of map drawers and community resource
Four	Primary data collection and use of participatory rural appraisal (PRA) tools	
Five	Focus group discussions on TDV 2025 first principal objective ' high quality of livelihood' Topics: food self sufficiency, and food security, universal Primary Education, gender equality and access to primary health	
Six	Further focus group discussions on TDV 2025 ' high quality of livelihood' Topics – access to reproductive health, infant and maternal mortality rates, access To safe water, life expectancy and objective poverty.	
Seven	FGD on TDV 2025 second and third principal objectives ' good governance' and 'rule of law'	
Eight	FG to prepare community plan	DG to prepare draft ward plan
Nine	Village council priorities specific objectives and Drafts three year community plan	Zonal/mtaa meeting to discuss and comment on the draft ward plan
Eleven	Extraordinary village assembly to receive and Approve community plans	WDC to prioritize all specific objectives, prepare and endorse The tree year ward plan
Twelve	Preparation of simple format by sector at ward level	

Source: Adopted from works of Odd – Heldge Fjeldstad et al (2010)

Recommendations

HRH planning and execution should be integrated into the O&OD planning framework to enable communities to take active roles in addressing HRH challenges. Community participation in HRH would include facilitation of accommodation to health workers and other facilitation at community level.

5.1.2 Personal Emolument (PE) Planning and Budgeting Process

The Personnel Emoluments (PE) planning and budgeting process is fundamental in addressing the issue of supply of health workers in the districts. It is through this process the establishment (required staffing levels) is approved by the government through a structured multi sector approach.

PE budgeting is part of an annual budgeting process through which institutions within the public service undertake an assessment, determination and approval of human resource requirements.

PE is carried out by every organisation in accordance with section 8 of the Public Service Act No. 8 of 2002. The rationale for PE budgeting is articulated in the Medium Term Strategic Planning and Budgeting Manual, as follows:

- determination of the number of employees required to enable organisations to implement their strategic plans and financial implications.
- ensure optimum utilisation of PE resources and alignment with MKUKUTA goals, and
- blending human resources development with strategies and skills requirements for smooth implementation of agreed strategies.

The budget process is governed by a body of laws, regulations and administrative procedures, and circulars issued by various government departments outlining regulations and procedures to be followed on personnel and financial planning and budget and related matters.

Table 5.2 below illustrates the PE planning and budgeting process as it applies in the public service in Tanzania.

Table 5.2 An illustration of the PE Planning and budgeting process

PROCESS	PROCESSS DESCRIPTION	ACTORS
Formulation of Macro- fiscal policy framework for the medium Term Budget	Involves development of the macro economic and fiscal framework, revenue projections and expenditures objectives and priorities. Includes setting of ceilings for the total wage bill including votes for LGAs	Budget Guidelines Committee (Multi sectoral)
Issuing Budget Guidelines /Circular for the Medium Term Budget:	The Ministry of Finance provides a guide on medium term budget policy and strategic framework including instructions for the preparation of the budget for the forthcoming fiscal year and medium term. Upon receipt of the circular, PO-PSM compiles all the details on the personnel emoluments clarifying the establishment; in –post, -existing vacancies plus pay roll details by VOTE. Using the complied data and information, a Circular is issued to all VOTES for verification and with a request to submit additional staff requirements with justification and financial implications.	MoFEA, POPSM
Preparation and submission of PE requirements by MDAs to PO-PSM.:	Upon receipt of the circular from PO-PSM, the institutions are expected to define the skill requirements, types and numbers of employees needed to implement the strategic plans over the medium term plus the budgetary implications. The exercise is undertaken within the policy and strategic guidance provided by PO-PSM. The submission oh human resource requirements is then submitted to PO-PSM for consideration and consolidation into a national framework for PE for the specified period.	POPSM/LGAs
Consultations on PE requirements with MDAs:	(Nov-Jan). The Directorate of Establishment organises consultative meetings with all the institutions at the centre, regions and LGAs to discuss their submission on PE budget for the forthcoming financial year for each VOTE. The intention of the meetings is to consider the supply of the skilled manpower required to fill in vacancies, the implications on overall wage bill and building consensus on the PE estimates. Which can be afforded within the indicative budget ceilings.	POPSM/LGAs
Submission of Proposed PE budget to PS (Establishment) for or consideration and Approval.	The Directorate of Establishments (PO-PSM) consolidates the deliberations on the PE estimates into a policy and strategic paper on PE and submits to PS /Establishment for consideration, approval and onward submission to MoFEA. In the following figure we summarise the budgeting and planning process which include planning and budgeting of human resources in Tanzania public service	POPSM/MoFEA

5.2 Limitations and constraints of the current PE planning and budgeting

Although the planning and budgeting process is said to be bottom – up, there is little evidence that the process provides adequate autonomy to local authorities to prioritise their plans independently. This is due to the fact that the PE budget follows specific guidelines set by the central government, which includes budget ceilings.

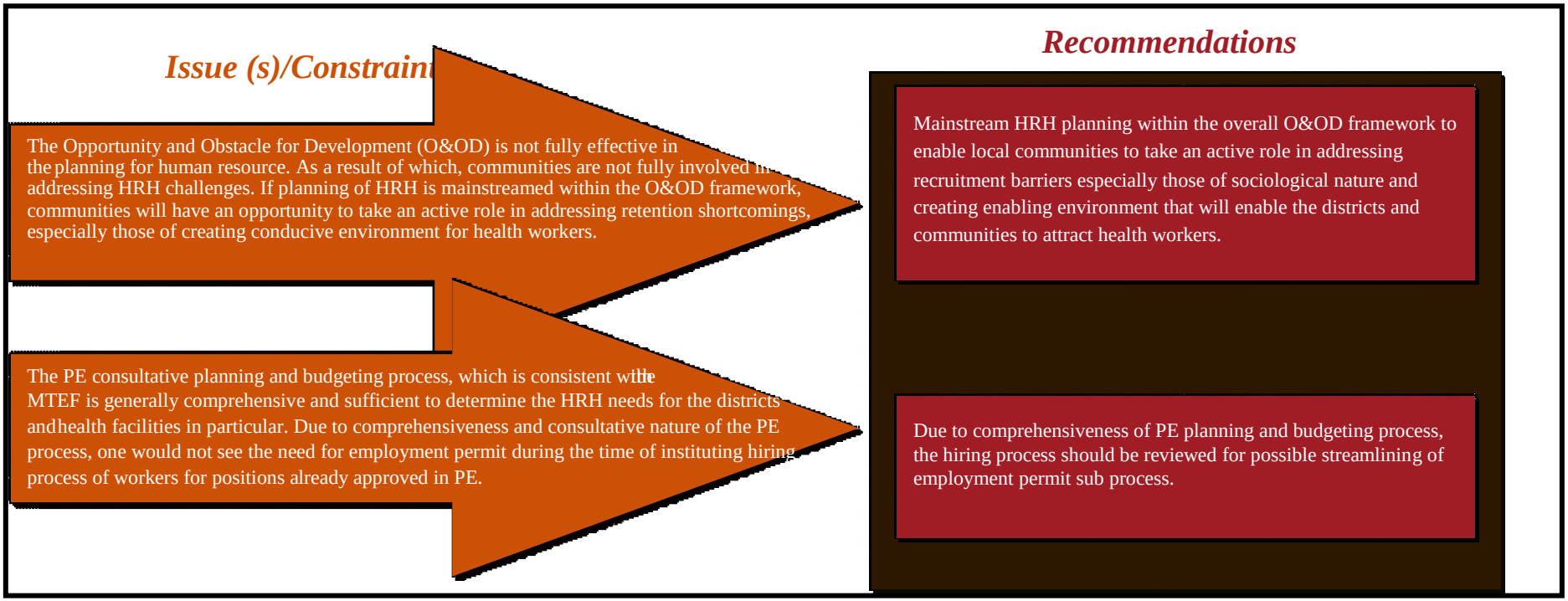
A recent study by Odd-Helge et al (January, 2010) indicates that in practice the national budget guidelines and ceilings are not received on time by LGAs. For example, in 2008/09 and 2009/10 fiscal years, LGAs received the budget ceilings in April. Consequently some LGA decided to use indicative budget ceilings for the previous year and local communities were not effectively involved in the budgeting and planning process.

The above facts may have been affecting objectivity in HRH planning and contributing to the shortage of key staff in some districts, especially those with less political influence.

5.2 Summary of limitations and constraints of the current PE planning and budgeting Process

A summary of issues and recommendations related to Planning and budgeting of human resources in the public service in Tanzania, as they relate to recruitment of health workers in LGAs have been captured in figure5.2 below.

Figure 5.1 Summary of issues and recommendations related to Planning and budgeting of human resources



5.3 Review of hiring processes

5.3.1 Centralisation Vs Decentralisation of recruitment of health workers

Currently, the recruitment of health workers for districts is centralised. The central ministry (MoHSW), since 2009 has became responsible for recruiting health workers and posting them to respective districts. Our interviews with the department of personnel and Administration (MoHSW) indicate that the centralised arrangement has the following justifications among others:

- Perceived low capacity of district councils to attract qualified health workers due to being geographical and economically challenged,
- The need to utilise the competitive advantages of the central ministry to access large numbers of potential candidates for easy of distribution and re-distribution,

Despite the centralisation of recruitment of health workers, still there are complaints of failures to fill vacant positions in the districts. During the review, we did not obtain sufficient evidence of inability of the LGA to handle successful recruitment campaigns. In the following table we indicate some of the strengths and weaknesses of the centralised recruitment of health workers.

Table 5.3 below summarises the strengths and weaknesses of a centralized recruitment arrangement as it applies to health workers being recruitment for LGAs in the Country.

Table 5.3 Strengths and Weaknesses of decentralised recruitment arrangement

Strengths	Weaknesses
• Easy to coordinate national-wide recruitment campaigns targeting candidates from public health institutions • Easy to implement bonding strategies and other compulsory arrangements to enable government sponsored students to work in rural areas on a compulsory basis	• Adverts are too general and are not targeted to attract candidates to a specific localities. Specific incentives attached to a position in particular station is not captured. • Adverts are generally not appealing in outlook and contents compared to those being placed by the private sector • The practice is not consistent with devolution of decision making principal which requires LGAs to make their own decisions in matters that affect them.

Remarks on centralisation

During the review, we were unable to obtain solid justifications for centralisation of recruitment of health workers for districts. While at central level centralisation is seen by interviewed personnel as an improvement initiative, the Author sees it as a strategy to centralise decision making powers.

5.3.2 Employment permits (for non emergency hiring)

The hiring process for district health workers is initiated by the DED, who submits request for hire of new staff to POPSM for scrutiny, indicating justifications for new hires. POPSM verifies the request against approved establishment within the vote and underlying justifications before approval. The hiring approval is then sent to MoHSW, who will recruit potential candidates, mainly through advertisements under a centralised arrangement. A recruited candidate who is willing to work at the advertised station is then posted to the respective district. The DHRO under the DED receives the posted candidates and completes employment formalities, including verification of certificates, completion of employment contact, payroll forms and placement the new hire to their respective duty station.

Recruitment on emergency basis occurs when an approved, and filled position, has fallen vacant due to death, resignation, etc. In these circumstances, the subsidiary permits apply and the Council through DHROs handle full recruitment campaigns.

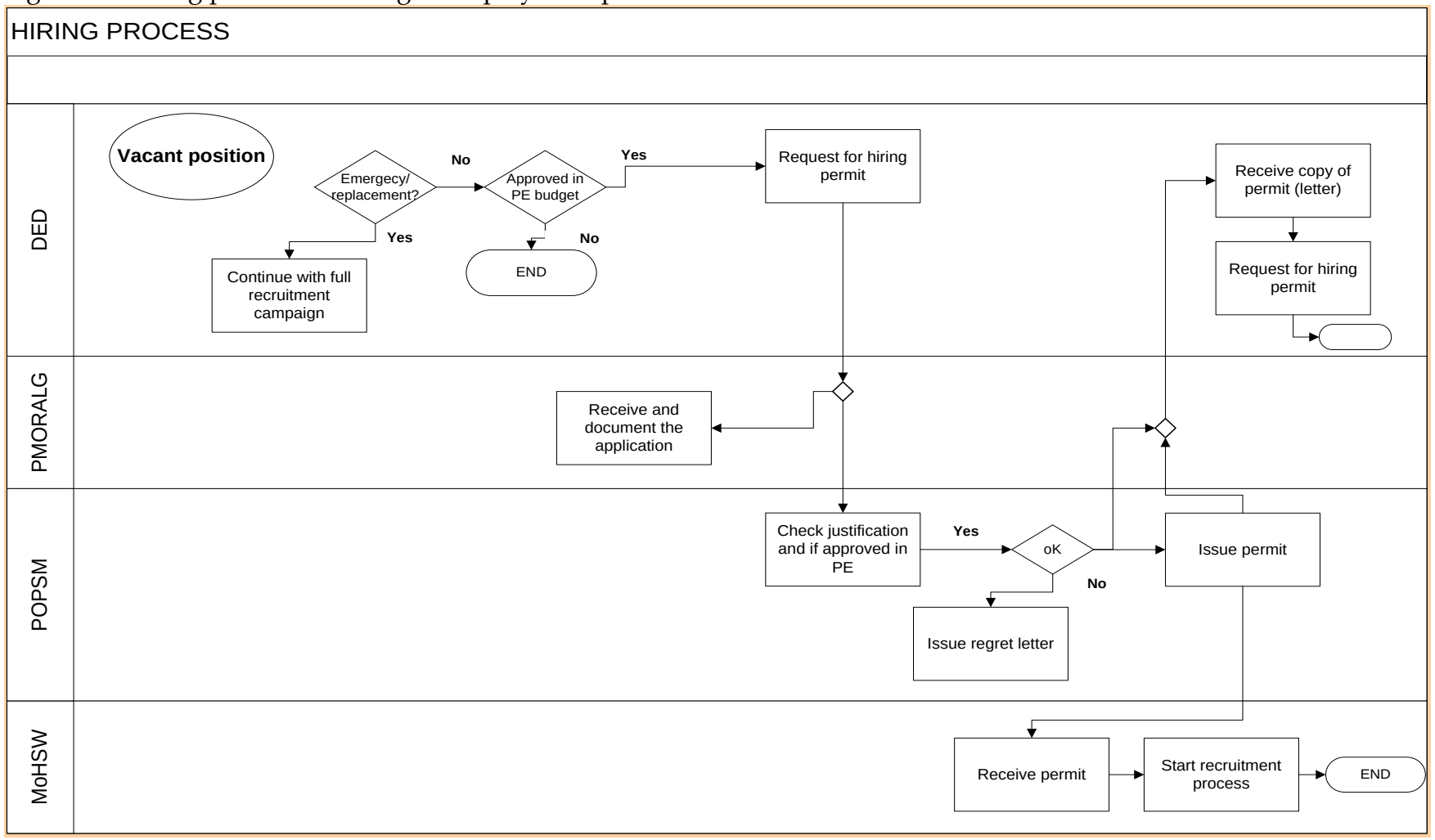
5.3.3 Observations:

Although there was no evidence of delays in issuance of employment permits during the review, the author of this review is of the opinion that applying for recruitment permits for positions that are already approved in the PE budget is seen as redundant, especially for health sector where there is shortage of staff and urgent need of filling vacant positions.

5.3.4 Hiring Process Map

The following figure 5.2 is a process map illustrating the hiring process of health workers in the LGAs. It captures the organisational units involved in the hiring process as well as the interface between various players.

Figure 5.2 Hiring process – relating to employment permits



5.4 Payroll enrolment and implication to staff retention

When a new health worker accepts an employment offer with the LGA, payroll forms are completed by DHRO and are submitted to POPSM for verification and enrolment of the staff into the payroll. POPSM (establishment) enrols the joiner into the payroll and submits the necessary papers to MoFEA (Treasury) for payroll activation.

Observations

We noted during the interviews with PMORALG officials that its takes up to three to four months from the reporting date of a new hire to be enrolled into the payroll. This was mentioned as one of the many factors that contribute to frustrations of new hires and hence high staff turnover rate.

The hiring process is adequate in-terms of providing checks and balances to avoid the payment to 'ghost workers'. Three units in different ministries are involved in the process including; DED, POPSM (Establishment) and MoFEA (Treasury).

The author of this study hold the view that the delay in the processing of payroll is not directly associated with the number of institutions involved in enrolment of personnel into the payroll through to payroll processing. Rather, the problem is a result of over congestion of the office of DHRO and accountability on part of different actors LGAs
The evidence to this is the results of the interviews with PMORALG officials who indicated that DHROs have been personally sending such documents to POPSM in Dar es Salaam.

Recommendations

The authors put forth the following recommendations in order to help improve the payroll processes and reduce attrition rate of new hires in the districts:

Long term strategy;

- Automation of payroll registration process by rolling out the payroll system in regional and district centres,

Short term interventions;

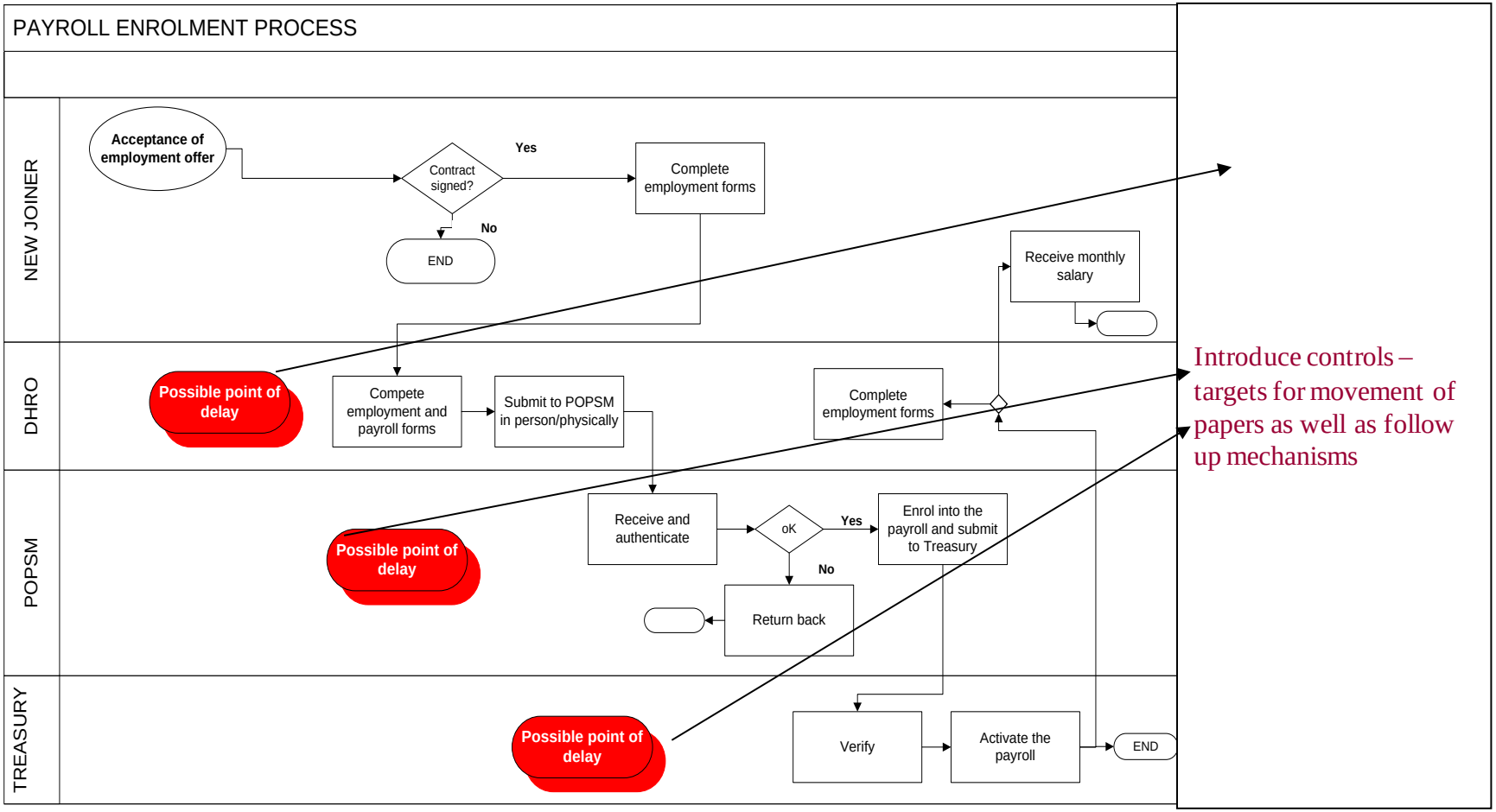
- Introduce check/control points within the process and enforce accountability to ensure smooth and timely movement of documents from the DED to Treasury

- Submission of payroll papers should continue to be handily and personally delivered to POPSM by district personnel. However, the DHSs may be involved in this role and DHROs be relieved of this duty

5.5 Payroll enrolment process map

The following figure 5.3 is a process map, indicating players involved in the payroll enrolment process at LGAs and Central Government. Interface between various units that are involved in the process as well as possible points of delay in enrolment process have been indicated.

Figure 5.3 Payroll enrolment process for district health workers



6. MACRO SOCIAL-ECONONOMIC AND POLITICAL FACTORS AFFECTING RECRUITMENT AND RETENTION OF HEALTH WORKERS

6.1 Overview

Studies and interviews attest that there are a number of macro-social, economic and political factors that are affecting the ability of LGAs to attract and retain various categories of workers, in various localities, including the health sector. These factors include the weak financial base of some LGAs, low public service pay, political influences in allocation of resources at LGAs as well as social systems such as norms, culture and beliefs in some areas. The next section will explore some of these factors and the way they could affect the recruitment and retention of health workers in districts.

6.2 Local Government Financing

Some interviewed informants indicated the weak financial position and inability of District Councils to introduce local incentives relate with inability of LGAs to attract, engage and retain qualified health workers. Our review indicates that the major source of LGA's financing is central government allocations, which amount for 72 % of the entire local authority budget. Local authorities can also raise revenue locally. The main sources of LG self generated revenue include:

- Fees from taxi registration, bus stands, forestry products, valuation, scaffolding, inoculation and ambulance,
- Licences including road, liquor
- Property taxes and rents (LGAs owned properties).
- Charges for refuse collection, hire of vehicles, markets etc,
- Fines, and
- Others including sale of assets and recovery of public fund.

The weak resource base for LGAs, may have been a barrier to some LGAs, especially those with weak or limited sources of revenue to initiate local incentives that would have helped to attract qualified health workers. However, since some regions and LGAs have initiated local incentive schemes (using own sources or through donor support), and to some extent they have minimised the problem of shortage of health workers, other districts may adopt similar initiatives. We further recommend the need for

deliberate government efforts to improve LGAs resource base necessary for introducing local incentives.

6.3 Public Service Pay

Previous studies on recruitment and retention challenges in Tanzania, including the pilot recruitment bottleneck study (2010) which preceded this review have identified low pay and inadequate pay strategies as critical factors affecting recruitment and retention of competent staff in districts, not only for health workers but also other skills needed by the public sector.

It is recognized that pay influences the behaviour of public servants. Kiragu and Mukandala (2005) identified pay as a key public service issue and points out that sustenance of motivation, performance and integrity of public servants in providing public service crucially depends on pay adequacy.

There are many consequences of low pay:

a) Government workers cutting back their productivity or hours of work. This can be seen through prevalence of absenteeism, alternative employment, rent seeking (such as the "per diem" and "sitting" allowance);

b) Difficulties or failure to recruit and retain professionals for some cadres.

Sources from POPSM – policy department indicated that the government was working on a Draft Public Service Pay Policy. The policy will address pay challenges identified in previous studies and integrate previous pay strategies. Previous strategies include the Medium Term Pay Reform Strategy (MTPRS). The draft policy was not made available to the authors due to it being in a confidential draft form.

Interviews further attests that the new policy will introduce strategies for attracting qualified workers to work in the districts, and especially underserved areas, not only in the health sector but other sectors.

6.4 Political Influences affecting recruitment and retention in districts

Studies indicate that at the districts, most decisions, including those related to planning and budgeting are politically driven, especially because they require sanctioning by the full council which is constituted by Councillors.

Odd-Helge at al (2010) in his analysis of participatory planning process in the districts indicated that all districts and community plans are submitted to the council for screening, prioritization and approval. He asserts that political decisions of the councils have been limiting the powers of the communities to influence resource allocation in their local areas especially, including health sector decisions in the districts.

Another limiting practice is where council committees allocate resources on locations that are critical for elections of respective councillors. Lack of objectivity in resource allocation for health facilities has been evident during political elections and where the council is constituted by multi party councillors. This situation has resulted in inequalities (social and other amenities) among the local communities. Communities with weak political representation have been facing challenges in attracting and retaining health workers in their dispensaries and health centres (Odd Helge, 2010).

6.5 Sociological factors affecting recruitment and retention in districts

It was evident during the review that some staff refuse to move to some districts or abscond shortly after reporting due to sociological factors. Sociological factors include: norms, beliefs and social systems that are present in communities. These beliefs, norms and social systems are considered immoral or threatening to some people who are not used to them. There are no statistics were not obtained during the review, to confirm the magnitude of the problem, interviews with POPOSM confirmed existence of this problem in some places. An example was sited during the interview where a young graduate (primary school teacher) was forced out of the duty station due to being unmarried. It was considered by the local community to be unsafe for the girls to be taught by unmarried teacher.

Sociological factors are complex to address. They range from simple life styles to complex science beyond material such as witchcraft. External interventions may not work out to resolve some social mores. Community involvement through participatory approaches may be appropriate interventions to address this problem. With will be achieved by integrating HRH issues in O&D framework.

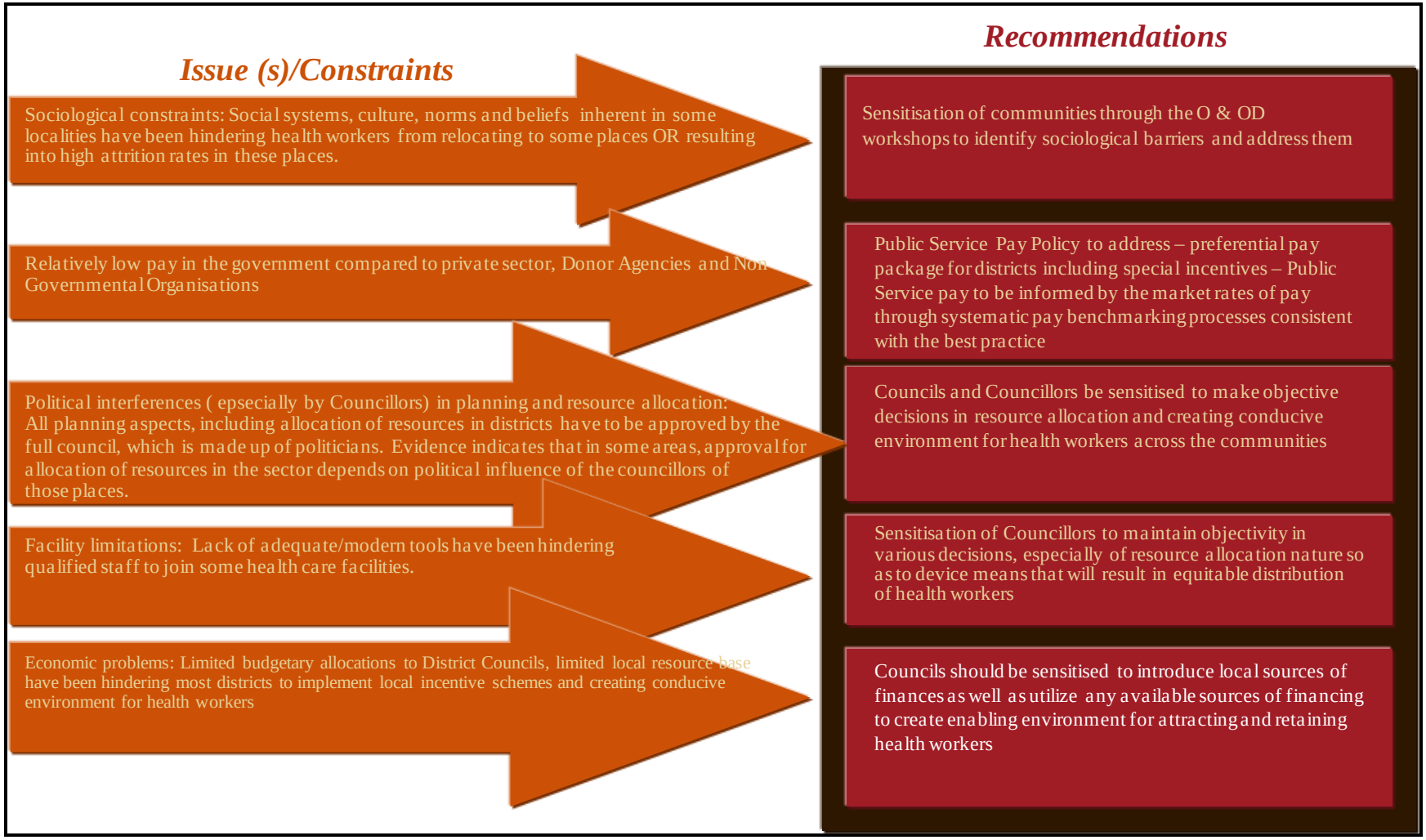
6.6 Limitations in health facilities

It was learnt during the interviews that some health facilities in districts and communities are not in condition and lack necessary working tools. This situation has been discouraging qualified health workers like qualified medical doctors to work in those health facilities. However, MMAM indicates facility modernisation as part of the strategy for improved health services in the country.

6.7 Summary of Social, Political and Economic constraints and recommended actions

The following figure 6.1 summarises various social, political and economic constraints hindering recruitment and retention of health workers in LGAs as well as recommended remedial actions that would reduce or eliminate these barriers and increase the ability of LGAs, especially in underserved areas to attract, recruit and retain require numbers and skills of health workers.

Figure 6.1 Summary of Social, Economic and Political Constraints affective recruitment and retentions in districts



7. LESSONS FROM SUCCESFUL STORIES OF RECRUITMENT AND RETENTION, SUMMARY AND NEXT STEPS

7.1 Overview

The previous chapters and sections of this report have illustrated the ~~than~~ districts and lower level health facilities are facing a severe shortage of qualified health workers despite various efforts of the government and other actors in the sector.

Although some districts, including non government health facilities have continued to suffer a severe shortage of health workers, some LGAs and health facilities have introduced local initiatives that have consequently reduced the problem of shortage of health workers. In the following parts of this report we highlight some success stories of recruitment and retention of health workers as picked from some districts during the review.

7.2 LGAs to train own people

A strategy to sponsor students who are natives and residents in certain localities was once practiced at Haydom Hospital in Mbulu District (PricewaterhouseCoopers, 2006), one of the prominent faith based owned hospital in northern part of the Country. This strategy entails sponsoring students who are natives and residents in respective districts, and who agree to work for the hospital once they complete their studies. The underlying assumption of this strategy is that these people are used to the local environment and will be happy to work within their native district. Although implementation of this strategy requires adequate resource base (educational fund), the report by PricewaterhouseCoopers (2006), indicates that this strategy has to some extent helped to minimise the problem of shortage of health workers at the facility (Haydom).

Possible limitations of sponsorship

As much as this strategy may help to minimize the problem of shortage of health workers, this strategy may be limited by a numbers of factors. One would be the need for strong institutional mechanisms to ensure that sponsored students come back to work in the respective communities on completion of their studies. To ensure this is the case, enforceable legal contracts (bonds) between the employer and a sponsored student, indicating permissible penalties that will be instituted to the prospective employee should he/she breach the contract must be in place.

7.3 Use of Local Incentive Schemes

The review indicates that districts which have introduced local incentives, over and above those provided in the public service regulations have managed to attract qualified health workers more than those which have not (pilot recruitment bottleneck study, 2009). These include Rukwa Regions, which have introduced relocation package and other local incentives through the support of Mwalimu Nyerere Fund.

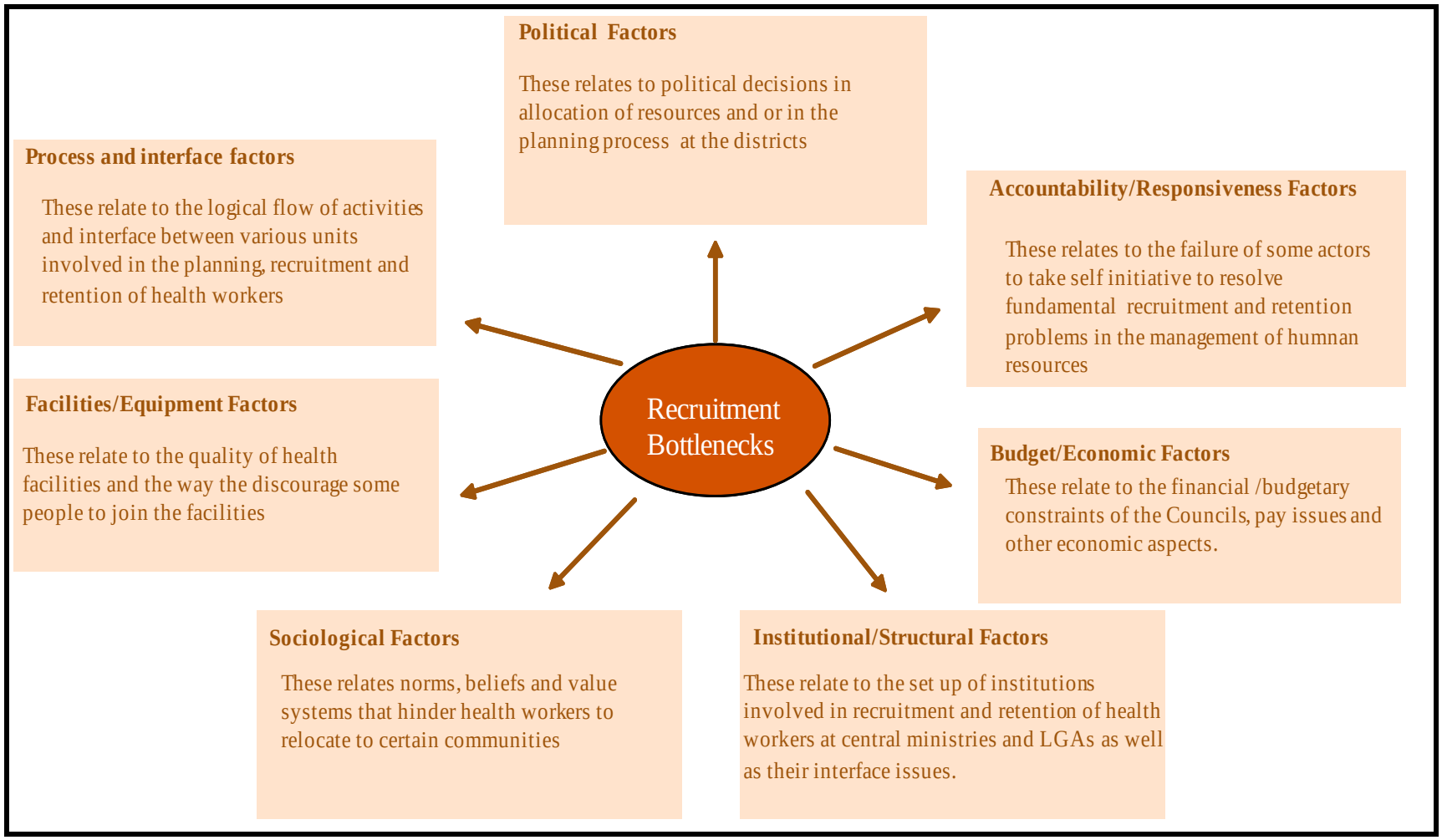
There is evidence of DHROs who visit the health training institutions to convince prospective graduates to join the public service in their districts. Some DHROs would make all necessary preparations to receive the new joiners, including transport arrangements, accommodation etc. These initiatives have been instrumental in recruitment and retention of not only the health workers but also other categories of staff such as secondary school teachers in the education sector (recruitment bottleneck pilot study, 2009).

7.4 Summary of recruitment and retention challenges

In the light of this review, we summarise the key challenges facing the health sector in the districts in their efforts to attract, engage and retain health workers. Economic, political and sociological factors were identified as some major constraints in the districts. Low level of production of various categories of health professionals by existing health training institutions in the country accelerates the problem of shortage of health workers in districts. I-TECH (2010) indicates that 75% of Clinical Officers/Clinical Assistants government training institutions are experiencing a severe shortage of full time tutors; hence low level of students enrolment. Further, issues related to institutional arrangement, processes and lack of initiatives in dealing with employment matters were identified as softer factors which could be dealt with at minimal costs, and yet improve the ability of LGAs to recruit and retain required numbers and quality of health workers.

Figure 7.1 below summarises some of the identified constraints which include; political, economic (budgetary), accountability and institutional/.structural factors. Others are factors related to working tools, sociological and process (interface) factors.

Figure: 7.1 Classification of major recruitment and retention challenges



7.5 Conclusion

The central concern of this review is to identify recruitment and retention constraints of health workers in the districts and possible ways of closing the gaps. The review has uncovered political, economical and sociological constraints. Others are systemic issues ranging from institutional and organisational arrangement, processes and accountability aspects surrounding the recruitment of health workers for districts.

Limited production of health professionals has been accelerating the problem, mainly due limited number of graduates being brought into the labour market each year. While interventions to some of these constraints like economic, political and sociological requires a multi-sector approach and substantial resources (time and financial), other constraints like institutional, organisational arrangement, process and accountability requires softer mechanisms to resolve. The softer factors are therefore considered as quick wins for the donor communities to support the government effort to reduce the magnitude of the problem.

7.6 Summary of recommendations

The following key recommendations are made with consideration that this will help decision makers at the Central and Local Government levels to make evidence-based decisions related to minimizing the gap between recruitment and retention in the districts.

This review recommends the re-definition and harmonization of the roles of various institutions that are mandated to handle recruitment and retention of health workers in and for the districts. These institutions include the Ministry of Health and Social Welfare (MoHSW), Prime Minister's Office Regional Administration and Local Government (PMORALG), President's Office Public Service Management (POPSM) as well as other organs such as the Employment Secretariat. Other institutions include the Councils Health Management Teams (CHMTs) and Employment Boards in the Districts.

Decongestion of the office of District Human Resource Officers (DHRO) could be eased by re-directing some human resources roles, especially those related to HRH, to Health Secretaries (HSs). It is envisioned that this would reduce delays in handling HR matters in the districts and subsequently improve staff satisfaction and retention.

In order to enhance the effectiveness of HRH planning, the review recommends mainstreaming HRH planning within the overall Opportunity and Obstacles to Development (O&OD) framework. Utilizing this framework could enable communities to take active roles in addressing recruitment and retention barriers at the community level. If the communities are actively involved, they may be able to help address local incentives such as housing problems as well as social constraints to recruitment at community level.

Modifying current HRH forecasting methodologies could help to better determine the actual HRH demand nationally, and in specific districts and communities. More precise forecasting methodologies will support the adoption of mechanisms for effective distribution and re-distribution of health workers throughout the country.

It is highly recommended that LGAs should consider introducing localized special incentives, over and above those described in public service policies and regulations in order to attract health workers in specific localities. Given the existing regional disparities, instituting local initiatives to address specific constraints at the LGAs level, as opposed to relying on central government directives would easily resolve the constraints. During the review, it was evident that LGAs which have introduced local incentives have resolved recruitment and retention bottlenecks to some extent (Bottleneck pilot study, 2009).[5]

LGAs should strive to address inherent sociological factors such as beliefs and socil values that have been negatively impacting on the efforts to attract and retain health workers in the districts.

Finally, it is recommended to building the capacity of local organs and actors such as CHMTs and DHROs to address previously identified recruitment constraints which necessitated centralization of recruitment of health workers for LGAs.

1.6 Remarks

The constraints to recruitment and retention of health workers in the districts require a nationwide and multi -sector approach that may require large resources. These constraints include: economic conditions, infrastructure, and LGA budget allocation. However, some softer constraints such as accountability, process improvement and instituting practical local initiatives may be eased by minimal efforts and resources.

[5] Recruitment Bottleneck study, a pilot assessment conducted by BMAF in 2009 in three districts provides useful information of various local initiatives and the impact in recruitment and retention.

7.3 Next Steps

In the light of the presented evidence based findings and recommendations, the following actions are recommended to be undertaken by the stakeholders:

- Spot major constraints to recruitment and retention of health workers in the districts as presented in this report and identify quick wins.
- Draw a comprehensive step-by-step action plan to be implemented within the short, medium and long term periods depending on resource availability and other dependencies.

SELECTED REFERENCES

1. Benjamin William Mkapa HIV/AIDS Foundation (BMAF), *Recruitment Bottlenecks- pilot study*, 2009 (unpublished report).
2. Crown Management Consultants et. Al *'Consultancy on Staffing Problems or Otherwise Disadvantaged Local Government Authorities'* Report Submitted to PMORALG, URT, November, 2005.
3. Health Workforce Initiative, *Fact Finding Report*, 2009.
4. Health Technical Review, Presentation, September, 17, 2009
5. International Training and Education Centre for Health (I-TECH), *A situational Analysis of Government Clinical Officer and Clinical Assistant Training Institutions in Tanzania*, March, 2010
6. J.D. Njau, Presentation; '*Existing HRH retention schemes in Tanzania: Evidence from selected case studies in four regions*', 2009
7. Kithinji Kiragu and Mukandara, Public Service Pay Reforms in Tanzania (2005)
8. Ministry of Health and Social Welfare, *Staffing Levels by Facility at District Level – 1999 – 2008* (Unpublished pamphlet),
9. Odd – Helge Fjeldstad, et al, ' Planning in Local Government Authorities in Tanzania: Bottom up Meets Top-down', 2010
10. PricewaterhouseCoopers (2006), Consultancy report on Capacity Assessment of Haydom Lutheran Hospital (unpublished).
11. School of Public Health and Social Sciences, Muhimbili University of Allied Sciences, Dar es salaam, *Analysis of the Constraints in Human Resource availability (training, recruitment, deployment and retention, especially in hard to reach areas, 2010*
12. The United Republic of Tanzania, Ministry of Health and Social Welfare, *Health Sector Policy,* June, 2007
13. The United Republic of Tanzania, President's Office Public Service Management, *Management and Employment Policy, Issue No. 2*, September, 2008.
14. The United Republic of Tanzania, Ministry of Health and Social Welfare, *Health Sector Strategic Plan III, July, 2009 – June, 2015 (Partnership for delivering MDGs)*
15. The United Republic of Tanzania, Ministry of Health and Social Welfare, *Primary Health Services Development Programme (PHSDP)*, May, 2007.
16. The United Republic of Tanzania, President's Office Public Service Management, *Public Service Reform Program Phase II* (2008 – 2012)
17. The United Republic of Tanzania, Ministry of Health and Social Welfare, *Consultancy on Rapid Assessment of Ongoing Enrollment Trends of Students in Health Training Institutions in Mainland Tanzania*, HRH Working Group, April, 2009
18. The United Republic of Tanzania, Ministry of Health and Social Welfare, *Human Resources for Health Strategic Plan, 2008 – 2013.* (January, 2008)
19. Tanzania Health Workforce Initiative (HWI), Fact Findings Field Findings to Underserved Areas (2009) – Unpublished presentation.

20. United Republic Of Tanzania *'Scaling Up Human Resource for Health, A Situational Analysis of Government Nursing Schools in Tanzania*, URT, 2010
21. Workers Retention in the Health Sector in Tanzania, Findings from 2007 Literature Review, Ministry of Health and Social Welfare/NIMR Capacity Project Partnership, 2007

LIST OF SELECTED PEOPLE WE CONSULTED/INTERVIEWED

S/N	NAME	TITLE	INSTITUTION
1	Mwakalukwa	AG. Director of Human Resources	MOHSW
2	Dr. Mwakalasya	DHR (Retired)	MOHSW
3		Quality Control	MOHSW
4	Mr. Mlay	Assistant Director/ Establishment	POPSM
5	Ms Meena	Assistant Director/Policy	POPSM
6	Miriam Mmbaga	Principal Human Resources Officer	PMORALG
7	Marko John	Principal Human Resources Officer	MOHSW
8	Rahel Sheiza	Human Resources Manager	BMAF
9	Dr. Adeline Saguti	Program Manager	BMAF